



TEXAS DEPARTMENT OF INSURANCE

Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)

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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name

MARK HENRY MD

Respondent Name

AMERISURE INSURANCE CO

MFDR Tracking Number

M4-15-2524-01

Carrier's Austin Representative

Box Number 47

MFDR Date Received

April 13, 2015

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "This letter is a formal appeal of the claim/services in question. Your organization incorrectly paid, or did not pay, the claim in question.

Services performed on the patient are part of a series of surgeries beginning with those performed on 10/09/13 that are defined **medical emergency** under the Texas Administrative Code Title 28 Part 1 Chapter 10 Subchapter A Rule 10.2 (see rule 15.) Therefore, pre-authorization is NOT required.

Since this is a medical emergency case, the Texas Administrative code Title 28 Part 2 chapter 134 Subchapter G Rule 134.600 applies, which states that the carrier is liable for all reasonable and necessary medical cost relating to the healthcare."

Amount in Dispute: \$1,594.18

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "In response to the Medical Fee Dispute filed by Henry, Mark Howard, no additional reimbursement is due. Documentation submitted with original billing and reconsiderations do not support emergency care. Receipt of first request for reconsiderations states claimant had emergency surgery dated Friday March 15, 2013 (see attached)

Please see E&M office visit notes (attached) dated 9/12/2014, 9/24/2014 and 10/08/2014 date of surgery. Claimant was offered surgical intervention or non-surgical care on all three occasions. Documentation does not support on 10/08/2014 an emergency procedure is necessary to support DWC emergency definitions as listed below. Preauthorization request was an option."

Response Submitted by: Amerisure Insurance

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
October 08, 2014	CPT Code 25607 and 73110	\$1,594.18	\$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.600 sets out the procedures for preauthorization, concurrent utilization review, and voluntary certification of health care.
3. 28 Texas Administrative Code §133.2 sets out the general rules for medical billing and processing.
4. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
 - Original denial no preauthorization
 - W3 – Additional payment made on appeal/reconsideration

Issues

1. Are the insurance carrier's reasons for denial or reduction of payment supported?

Findings

1. The insurance carrier denied disputed services with claim adjustment reason code "Original denial no preauthorization" and W3 – "Additional payment made on appeal/reconsideration."

28 Texas Administrative Code §134.600(c) requires that "The insurance carrier is liable for all reasonable and necessary medical costs relating to the health care: (1) listed in subsection (p) or (q) of this section only when the following situations occur: (A) an emergency, as defined in Chapter 133 of this title (relating to General Medical Provisions)."

28 Texas Administrative Code §133.2(5) states: " Emergency--Either a medical or mental health emergency as follows: (A) a medical emergency is the sudden onset of a medical condition manifested by acute symptoms of sufficient severity, including severe pain, that the absence of immediate medical attention could reasonably be expected to result in: (i) placing the patient's health or bodily functions in serious jeopardy, or (ii) serious dysfunction of any body organ or part; (B) a mental health emergency is a condition that could reasonably be expected to present danger to the person experiencing the mental health condition or another person."

Review of the submitted information finds that the documentation provided by the requestor does not support emergency care in accordance with 28 Texas Administrative Code §133.2. The insurance carrier's denial reason is supported. Additional reimbursement cannot be recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is \$0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to \$0.00 reimbursement for the disputed services.

Authorized Signature

Signature

Medical Fee Dispute Resolution Officer

6/26/15
Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.